

1710

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Kent		MARYLAND		STATE Maryl nd		COUNTY Kent	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Rock Hall		life		OR TOWN Rock Hall X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Piney Neck Section				STREET ADDRESS (If rural give location) Piney Neck Section			
3. NAME OF DECEASED: (First) Herman (Middle) C. (Last) Berg				4. DATE (Month) (Day) (Year) OF DEATH: Feb. 17, 1955			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: June 2, 1890	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer		10B. KIND OF BUSINESS OR INDUSTRY: Owner		11. BIRTHPLACE (State or foreign country): Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Herman Berg				14. MOTHER'S MAIDEN NAME: Matilda Grulkey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. no		17. INFORMANT & ADDRESS: Herman Hill, Rock Hall, Md. son			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pulmonary Edema						8 hrs	
ANTECEDENT CAUSE (S) DUE TO Carcinoma of Bladder							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Metastasis of lungs							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cardiac Hypertrophy							
19A. DATE OF OPERATION: 6-3-54		19B. MAJOR FINDINGS OF OPERATION: Generalized Carcinomatosis				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-28- , 19 54 , to 2/17/ , 19 55 , that I last saw the deceased alive on Feb 17 , 19 55 , and that death occurred at 3:15 PM , from the causes and on the date stated above.							
SIGNATURE Herbert C. Mutch		M. D. Rock Hall Md.		DATE SIGNED Feb 18 - 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/20/1955		NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		LOCATION (City, town, or county) (State) Rock Hall, Md.	
DATE REC'D BY LOCAL REGISTRAR 2/20/1955		REGISTRAR'S SIGNATURE S. Elwood Burgess		24. FUNERAL DIRECTOR J. Willis Wells		ADDRESS Chestertown, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 2 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01683

CERTIFICATE OF DEATH

Reg. Dist. No.....

Item 9, Film G177 2-28-55 et

1. PLACE OF DEATH COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Rock Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Point Gratitude</u>		STREET ADDRESS (If rural give location) <u>Point Gratitude</u>	
3. NAME OF DECEASED (Type or Print) <u>ELIZABETH BLIZZARD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 20, 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Approx. 82</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>82</u> yrs. If under 1 year If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gettman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT <u>Mrs. Annette Woolford, Rock Hall, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/19, 1955, to 2/20, 1955, that I last saw the deceased alive on 2/20, 1955, and that death occurred at 11:45 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 23, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>First United Evan.</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>2-23-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Ullrich Funeral Home</u>	ADDRESS <u>4210 Belair Road.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1712

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Kent</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Kent</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Millington</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Millington</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<i>MOLLIE P. BOGGS</i>		<i>Feb. 6 1955</i>	
5. SEX: <i>F.</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>May 5, 1873</i>
9. AGE last birthday: <i>81</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>	
11. BIRTHPLACE (State or foreign country): <i>Del.</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>John W. Pratt</i>		14. MOTHER'S MAIDEN NAME: <i>Sarah Wright</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service): <i>No</i>		16. SOCIAL SECURITY No.: <i>none</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Sadie Stevens Millington Md.</i>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<i>492X</i>		
Immediate cause (a) <i>Virus Pneumonia</i>		<i>5 DAYS</i>
Antecedent causes (s) (b) <i>GENERALIZED ARTERIOSCLEROSIS</i>		<i>15 YEARS</i>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)		

11. OTHER SIGNIFICANT CONDITIONS		12. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?	

22. I hereby certify that I attended the deceased from <i>JULY</i> , 1951., to <i>FEB 6</i> , 1955., that I last saw the deceased alive on <i>FEB 6</i> , 1955., and that death occurred at <i>7:45 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Stanley J. Lagana</i>		DATE SIGNED <i>FEB 7, 1955</i>	
(Degree or title)		ADDRESS <i>SMYRNA DPL</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>Feb. 9, 1955</i>	<i>Old Fellows Cem.</i>	<i>Smyrna Del.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>Feb. 8, 1955</i>	<i>Edward Fellows</i>	<i>Edward Fellows</i>	<i>Millington Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU Y. S.

FEB 11 1955

RECEIVED

1702

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Kent		MARYLAND		STATE Md.		COUNTY Kent	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
37 TOWN Chestertown		life		37 TOWN Chestertown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
10 Kent St.				Kent St.			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
W.		Raymond		Bowers		2/28/55 19	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
male		white		married		Jan. II, 1884	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.		yrs. Months Days Hours Min.	
71							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
self employed carpenter				Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
J. Raymond Bowers				Mary Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
no				218-07-8736		Mrs. Lydia Bowers Chestertown, Md wife	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) Coronary thrombosis 6 days							
ANTECEDENT CAUSE (S) (B) Coronary arteriosclerosis - don't know							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Auricular fibrillation 10 years							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 1951, to 2/28, 1953, that I last saw the deceased alive on 2-28, 1953, and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
Robert W. Fan				Chestertown, Md		3/1/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3/3/1955		Chester Cemetery		Chestertown, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
March 1-1955		Clara L. Barnes		J. Willis Wells - Chestertown, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 3 1955

RECEIVED

01686

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1703

CERTIFICATE OF DEATH

Reg. Dist. No. 2.02

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>216 Calvert</u>		STREET ADDRESS (If rural, give location) <u>216 Calvert</u>	
3. NAME OF DECEASED (First) <u>Ida</u> (Middle) <u>Elizabeth</u> (Last) <u>Brown</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>12-24, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>65</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Simon Smith</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>Augusta Ward</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>don't know</u>	
17. INFORMANT AND ADDRESS <u>Charles Brown</u>		17. INFORMANT AND ADDRESS <u>Chestertown, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2-4, 1953, to 2-26, 1955, that I last saw the deceased alive on 2-21, 1955, and that death occurred at 4:30 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/2/55</u>	NAME OF CEMETERY OR CREMATORY <u>Rich Neck Hall Cemetery</u>	LOCATION (City, town, or county) <u>Queen Anne Co., Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>March 1-1955</u>	REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	24. FUNERAL DIRECTOR <u>J. Willis Wells - Chestertown, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 3 1955

RECEIVED

1704 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Kent		MARYLAND		STATE Maryland		COUNTY Kent	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
37 TOWN Chestertown		29 years		37 TOWN Chestertown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 Mt. Vernon Ave.				1			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(Type or Print) Lizzie E. Collins				OF DEATH: 2/12/1955 19			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
female	white	single	Mar. 2, 1868	86 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Housework						Laurel, Del.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Isaac E. Collins				Sarah Phillips			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
no				no		Mrs. Helen Bowers Chestertown, Md.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Heart failure, congestive</u> 2 years							
ANTECEDENT CAUSE (S) (B) <u>Myocardial degeneration</u> 2 years							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary arteriosclerosis</u> - 2 years							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1952 to 2-12-55, 1955 that I last saw the deceased alive on 2-12-55, 1955, and that death occurred at 3:00 AM, from the causes and on the date stated above.							
SIGNATURE <u>Robert W. M.D.</u>				ADDRESS <u>Chestertown, Md.</u>		DATE SIGNED <u>2/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial				2/15/55		Chester Cem.	
LOCATION (City, town, or county) (State)				24. FUNERAL DIRECTOR ADDRESS			
Chestertown, Md.				J. Willis Wells - Chestertown, Md.			
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE			
Feb. 15-1955				Clara S. Barnes.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 17 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1705

CERTIFICATE OF DEATH

Reg. Dist. No. 016882

1. PLACE OF DEATH: COUNTY Kent MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) 37 Chestertown TOWN life HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Kent & Calvert Sts.		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Kent CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 37 Chestertown STREET ADDRESS (If rural give location) 1 Kent & Calvert Sts.	
3. NAME OF DECEASED: (Type or Print) Julia A. Flowers		4. DATE (Month) (Day) (Year) OF DEATH: 2/27/55 19	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Jan. 30. 1888
9. AGE last birthday 67 yrs.		IF UNDER 1 YEAR Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Geo. W. Adams		14. MOTHER'S MAIDEN NAME: Mary A. Adams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT & ADDRESS: Otis Flowers		Chestertown, Md. son	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) Cerebro-vascular accident @ 24 hr. ANTECEDENT CAUSE (S) DUE TO (B) Arteriosclerosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH 24 hr. ?
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-23 , 19 55 , to 2-27 , 19 55 , that I last saw the deceased alive on 2-26 , 19 55 , and that death occurred at 8 A.M. , from the causes and on the date stated above. SIGNATURE R. M. Atkins ADDRESS Chestertown DATE SIGNED 2-28-55 M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/2/55	
NAME OF CEMETERY OR CREMATORY Chester Cem.		LOCATION (City, town, or county) (State) Chestertown, Md.	
DATE REC'D BY LOCAL REGISTRAR March 1-1955		REGISTRAR'S SIGNATURE Clara S. Barnes	
24. FUNERAL DIRECTOR J. Willis Wells		ADDRESS Chestertown, Md	

BUREAU V. S.

MAR 3 1955

RECEIVED

MARYLAND

1713

CERTIFICATE OF DEATH

01689
STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 201

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Kennedeville</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>X</u> TOWN <u>Kennedeville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles A</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>Feb 5</u> 19 <u>55</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 29 1874</u> 80 yrs. (Month) (Day) (Year)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Market</u>	
11. BIRTHPLACE (State or foreign country) <u>Kennedeville md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hessner</u>		14. MOTHER'S MAIDEN NAME <u>Agusta J Hamilton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>219-07-50-09</u>	
15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>501X Bronchitis</u>			
Antecedent cause(s) (b) <u>malnutrition</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 15, 1955</u> to <u>Feb 6, 1955</u> , that I last saw the deceased alive on <u>Feb 6, 1955</u> , and that death occurred at <u>5:30 P.</u> from the causes and on the date stated above.			
SIGNATURE <u>L. P. Atwell M.D.</u>		ADDRESS <u>Blue Pond md</u> DATE SIGNED <u>Feb 7, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>2/8/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Galena Cemetery</u>		LOCATION (City, town, or county) <u>Galena md</u> (State)	
DATE RECD BY LOCAL REG. <u>2/1/55</u>		REGISTRAR'S SIGNATURE <u>Re Kennard Jones</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>10 R Fellows Ballford md</u>	

Bronchitis
Malnutrition

BUREAU V. 3

FEB 11 1955

RECEIVED

MARYLAND 1714

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>KENT</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>X</u> TOWN <u>KENNEDYVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>KENNEDYVILLE</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>WILHELMINA MARY HURLOCK</u>		4. DATE OF DEATH <u>FEB. 16, 1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB. 9, 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9. AGE last birthday <u>83</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES HURLOCK</u>		14. MOTHER'S MAIDEN NAME <u>AUGUSTA HAMILTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If year, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>WILLIAM HURLOCK, KENNEDYVILLE, MD.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
501X Immediate cause (a) <u>Bronchitis</u>			<u>3 weeks</u>
Antecedent cause(s) (b) <u>Anemia & Malnutrition</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Malnutrition</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>Feb 16, 55</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE OF INJURY (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Feb 15, 1955</u> , to <u>Feb 16, 1955</u> , that I last saw the deceased alive on <u>Feb 16, 1955</u> , and that death occurred at <u>9 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>L. P. Altwegg</u>		ADDRESS <u>St. Johns, Kennedyville, MD.</u>	
23. BURIAL, CREMATION, OR OTHER (Specify) <u>BURIAL</u>		DATE <u>FEB. 19, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>GALENA CEMETERY</u>
LOCATION (City, town, or county) <u>GALENA MD.</u>		DATE SIGNED <u>Feb 18, 1955</u>	
24. FUNERAL DIRECTOR REG. <u>218/55</u>		ADDRESS <u>B.R. Fellows STILL POND, MD.</u>	

MARGIN RESERVED FOR BINDING

Bronchitis

Anemia.

Malnutrition

BUREAU

FEB 24 1955

RECEIVED

1706

CERTIFICATE OF DEATH

Reg. Dist. No. 502

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Kent		MARYLAND		STATE Maryland COUNTY Kent			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chestertown, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Kent & Queen Anne Hospital		STREET ADDRESS (If rural give location) 309 Calvert St.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
Elizabeth Kennard				Feb. 13, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
female	colored	widowed	3/25/1889	65 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housework				Maryland		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Alfred Johnson				Harriett Derry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
no		no		Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Thrombia							
ANTECEDENT CAUSE (S) Cause unknown							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-7 , 1955, to 2-13 , 1955, that I last saw the deceased alive on 2-12 , 1955, and that death occurred at 4 A.M. , from the causes and on the date stated above.							
SIGNATURE R. M. Perkins		M. D. Chestertown		DATE SIGNED 2-14-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2/16/1955		Pomona Cem.		Kent Co. Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Feb. 15-1955		Clara S. Barnes		J. Willis Wells - Chestertown, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 17 1955

RECEIVED

MARYLAND

1715

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Rock Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Piney Neck</u>		STREET ADDRESS (If rural, give location) <u>Piney Neck</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna Sprout</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>7</u> (Year) <u>1953</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 18 1876</u>
9. AGE last birthday <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Christiana Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Sprout</u>		14. MOTHER'S MAIDEN NAME <u>May Rebecca Slohon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Morris Paschall Jr. - Rock Hall, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) <u>Arteriosclerotic heart disease</u>		<u>several years</u>	
Immediate cause <u>420.0</u>			
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension and congestive heart failure</u>		<u>years</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>Feb. 7</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Feb 4</u> , 19 <u>53</u> and that death occurred at <u>6 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Billard F. Smith MD</u>		DATE SIGNED <u>Feb 7, 53</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Concord Friends Meeting</u>	
DATE <u>Feb. 8, 1953</u>		LOCATION (City, town, or county) <u>Concordville Pa.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 7/53</u>		24. FUNERAL DIRECTOR <u>Marvin V. Williams - Chesterton Md.</u>	
REGISTRAR'S SIGNATURE <u>S. Elwood Burgess</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 10 1935

RECEIVED

01693

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1716

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH: COUNTY <u>Rock Hall, Kent Maryland</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Rock Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rock Hall</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>Rd 1</u>	
3. NAME OF DECEASED (First) <u>James</u> (Middle) <u>Reynolds</u> (Last) <u>Moore</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>28</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 31/1874</u>
9. AGE last birthday <u>80</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Moore</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann Reynolds</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>164-20-1558</u>	
(If yes, give war or dates of service)		17. INFORMANT <u>Ch. Moore Elton Ind.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>611X</u> <u>Senility</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Prostatitis</u>		
(c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <u>Yes</u> <u>No</u>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan. 7, 1955, to Feb. 28, 1955, that I last saw the deceased alive on Feb. 27, 1955, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

E. Keister M.D.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/2/55</u>	<u>Worshipful Cemetery</u>	<u>Towson Del.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Feb 28, 55</u>	<u>S. Elwood Singers</u>	<u>E. Keister</u>	<u>Danville Middletown Del.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 7 1955

RECEIVED

MARYLAND

1717

01694
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH- COUNTY Kent MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Kent	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Rock Hall		CITY (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
TOWN Rock Hall		TOWN Rock Hall	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Greys Inn		STREET ADDRESS Greys Inn	
3. NAME OF DECEASED (First) (Middle) (Last) WILLIAM HENRY SMITH		4. DATE OF DEATH (Month) (Day) (Year) Feb. 25/55	
5. SEX M.	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Jan. 15/1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	9. AGE last birthday 81 yrs.
11. BIRTHPLACE (State or foreign country) Rock Hall, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Simon Smith		14. MOTHER'S MAIDEN NAME Ida Perkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS Blanche Smith-Rock Hall, Md.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a).....		Palmonary Aedema	unknown
Antecedent cause(s) (b).....		Cardiovascular atherosclerosis	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....		Senility	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 1, 1955, to Feb 25, 1955, that I last saw the deceased alive on Feb 25, 1955, and that death occurred at 5:50 P.M., from the causes and on the date stated above.

SIGNATURE *Robert C. Hiteck* (Degree or title) ADDRESS *Rock Hall* DATE SIGNED *2/25/55*

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 2/28/55	NAME OF CEMETERY OR CREMATORY Sharptown Cemetery	LOCATION (City, town, or county) Rock Hall, Md.
DATE REC'D BY LOCAL REG. Feb 28/55	REGISTRAR'S SIGNATURE <i>S. Howard</i>	24. FUNERAL DIRECTOR <i>Marvin V. Williams</i>	ADDRESS <i>Chestertown, Md.</i>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 7 1955

RECEIVED

1718

CERTIFICATE OF DEATH

01695
Reg. Dist. No. 200

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Kent</i>	MARYLAND	STATE <i>md.</i>	COUNTY <i>Kent</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Salina</i>	LENGTH OF STAY (in this place) <i>Life</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Salina</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED: (Type or Print) <i>MARY</i> (First) <i>L.</i> (Middle) <i>TILGHMAN</i> (Last)		4. DATE OF DEATH: <i>Feb</i> (Month) <i>45</i> (Day) <i>1955</i> (Year)	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>Cal</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>widowed</i>	8. DATE OF BIRTH: <i>Nov 13 1877</i>
9. AGE last birthday: <i>77</i> yrs.		10. CITIZEN OF WHAT COUNTRY? <i>usa.</i>	
11. BIRTHPLACE (State or foreign country): <i>Salina md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>usa.</i>	
13. FATHER'S NAME: <i>Permy Scott</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Ann Sumic</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>—</i> (If Yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY No.: <i>none</i>	
17. INFORMANT & ADDRESS: <i>Hester B. Wilson Salta md.</i>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<i>420.0</i>		
Immediate cause	(a) <i>Ventricular Fibrillation</i>	<i>2 min</i>
Antecedent causes (s)	(b) <i>Arteriosclerotic Heart Disease</i>	<i>years</i>
(c)		

11. OTHER SIGNIFICANT CONDITIONS		12. CITIZEN OF WHAT COUNTRY?	
Conditions contributing to the death but not related to the disease or condition causing death. <i>Rt side hemiplegia due to cerebral vascular accidents</i>			
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY ?	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <i>April 1, 1954</i> , to <i>Feb 5, 1955</i> , that I last saw the deceased alive on <i>Feb 5, 1955</i> , and that death occurred at <i>10:20 a.m.</i> from the causes and on the date stated above.			
SIGNATURE (Degree or title) <i>Wallace Oberman M.D.</i>		ADDRESS <i>Pecilton md</i>	
DATE SIGNED <i>Feb 10 1955</i>		DATE SIGNED <i>7 Feb 55</i>	
23. BURIAL CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>Feb 10 1955</i>	<i>Oliver Hill Cem.</i>	<i>Rural Salina md.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>Feb 10 1955</i>	<i>Elizabeth J. Mulford</i>	<i>Edward Bellows</i>	<i>Millington md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1713

RECEIVED
FEB 11 1935
BUREAU V. S.

1707

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>37</u> <u>Chestertown</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Still Pond.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>72</u> <u>Kent and Queen Anne's Hosp</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>WALLEY</u>				<u>Feb 23 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Male</u>	<u>Negro</u>	<u>Single</u>	<u>Feb 23 1955</u>				<u>28 25</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Samuel Green</u>				<u>Mary Frances Walley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:		
<u>No</u>							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE			(A) <u>Prematurity</u>				<u>28 hr 23 min</u>
ANTECEDENT CAUSE (S)			DUE TO				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(B) DUE TO				
			(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>2-23</u> , 19 <u>55</u> to <u>2-25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-24</u> , 19 <u>55</u> , and that death occurred at <u>2:50</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>R. M. Adkins</u>			M. D. <u>Chestertown</u>		DATE SIGNED <u>2-25-55</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)			DATE THEREOF		NAME OF CEMETERY OR CREMATORY		
<u>Burial</u>			<u>2-26-55</u>				
DATE REC'D BY LOCAL REGISTRAR			REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS		
<u>2-25-1955</u>			<u>Clara S. Barnes</u>		<u>Family, Still Pond, md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 28 1955

BUREAU V. S.

1708

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Kent</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Kent</u>
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>37 Chestertown</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rock Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>72 Kent and Queen Anne's</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Clara</u>	(Middle)	(Last) <u>Warner</u>	OF DEATH: <u>February 11 1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married Apr. 26-1886</u>	8. DATE OF BIRTH: <u>68 yrs.</u>
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Edward Rodney</u>	
14. MOTHER'S MAIDEN NAME: <u>Henrietta Downey</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>—</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Mr. August Warner, Rock Hall, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cardiac decompensation</u>			<u>48 hrs</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Myocarditis, probably rheumatic</u>			<u>Years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>1-28-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Cholelithiasis</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12-21</u> , 19 <u>54</u> to <u>2-11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-11</u> , 19 <u>55</u> , and that death occurred at <u>12:30</u> pM, from the causes and on the date stated above.			
SIGNATURE <u>A. Sick</u>		DATE SIGNED <u>2-11-55</u>	
ADDRESS <u>Chestertown, Md.</u>		M. D.	
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/14/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		LOCATION (City, town, or county) (State) <u>Rock Hall Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 14-1955</u>		REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>	
FUNERAL DIRECTOR <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 16 1955

RECEIVED

1719

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Kent</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Kent</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Millington</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Millington</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED: (Type or Print) <i>ISABELLE S. WEIST</i>		4. DATE OF DEATH: (Month) <i>Feb.</i> (Day) <i>3</i> (Year) <i>1955</i>	
5. SEX: <i>F.</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>April 18, 1884</i>
9. AGE last birthday: <i>70</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>Md.</i>	
11. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Samster at Home</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>John F. Weist</i>		14. MOTHER'S MAIDEN NAME: <i>Lydian Barton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY No.: <i>none</i>	
17. INFORMANT & ADDRESS: <i>Miss Carrie Weist, Millington Md.</i>			

18. MEDICAL CERTIFICATION		Intervs Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <i>Glomerulo nephritis</i>		<i>5 weeks</i>
Immediate cause DUE TO		
(b) <i>Virus pneumonia</i>		<i>7 weeks</i>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO		
(c)		

11. OTHER SIGNIFICANT CONDITIONS		12. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
13. DATE OF OPERATION:		14. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		22. PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR ?			

22. I hereby certify that I attended the deceased from <i>12.12</i> , 19 <i>54</i> , to <i>2.3</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Feb. 3</i> , 19 <i>55</i> , and that death occurred at <i>10.05 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Edna Kralewski</i>		ADDRESS <i>Millington</i>	
DATE SIGNED <i>2.4.55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Feb. 7, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Millington Cem.</i>		LOCATION (City, town, or county) (State) <i>Millington, Kent Co. Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Feb. 4, 1955</i>		REGISTRAR'S SIGNATURE <i>Edward Fellows</i>	
24. FUNERAL DIRECTOR <i>Edward Fellows</i>		ADDRESS <i>Millington, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 11 1955

BUREAU V. S.

MARYLAND 1709

01699
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 2.02

1. PLACE OF DEATH: COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>N.Y.</u> COUNTY <u>LEWIS</u>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>CHESTERTOWN</u> LENGTH OF STAY (In this place) <u>3d.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LOWVILLE RD 3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>KENT + QUEEN ANNE'S</u>				STREET ADDRESS (If rural, give location) <u>69X-3</u> ✓			
3. NAME OF DECEASED (Type or Print) <u>REUBEN</u> (First)		(Middle) <u>L.</u>		(Last) <u>ZEHR</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>27</u> <u>1955</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>7-1-1900</u>	
9. AGE last birthday <u>54</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELEC. CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELEC.</u>		11. BIRTHPLACE (State or foreign country) <u>CROGHAN, N.Y.</u>	
13. FATHER'S NAME <u>JOSEPH B. ZEHR</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA KIPFER</u>			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)				16. SOCIAL SECURITY No. <u>Yes</u>			
17. INFORMANT AND ADDRESS <u>MARION ZEHR (WIFE)</u>				<u>SAME</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 Immediate cause (a) <u>PULMONARY EDEMA</u>						1 hr.	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>CONGESTIVE HEART FAILURE</u>						5d.	
(c) <u>MYOCARDIAL INFARCTION</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>DUE TO CORONARY OCCLUSION</u>						10d.	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-24</u> , 19 <u>55</u> , to <u>2-27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-27</u> , 19 <u>55</u> , and that death occurred at <u>7:08</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>R.M. Atkins, M.D.</u>				ADDRESS <u>Chestertown</u>			
DATE SIGNED <u>2-27-55</u>							
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>3/2/1955</u>		NAME OF CEMETERY OR CREMATORY <u>1st. Menonite Church Cemetery New Bremen</u>		LOCATION (City, town, or county) (State) <u>Lewis County N. Y.</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 27, 1955</u>		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>		24. FUNERAL DIRECTOR <u>J. Willis Wells - Chestertown, Md</u>			

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 1 1955

RECEIVED